

Prototype Parent/Guardian Notification for Medicaid/SCHIP

Dear Parent/Guardian

Children with health insurance are more likely to get preventive health care and care when they are sick. This results in fewer absences from school because of illness and children coming to school ready to learn. If your children do not have health insurance, you will be interested to know that many families getting free and reduced price school meals can also get free or low-cost health insurance for their children. However, many families do not know about the health insurance programs available to them.

The law now allows us to share your free and reduced price meal eligibility information with Medicaid and the State children's health insurance program. Medicaid and the State children's health insurance program can only use the information to identify children who may be eligible for free or low-cost health insurance and to enroll them in either Medicaid or the State children's health insurance program. They are not allowed to use the information from your free and reduced price school meal application for any other purpose. Medicaid officials or officials with the State children's health insurance program may contact you to get more information.

You are not required to allow us to share information from your children's free and reduced price meal application with Medicaid or the State children's health insurance program. It will not affect your children's eligibility for free and reduced price meals. If you do **not** want your information shared with Medicaid or the State children's health insurance program, you must let us know. You may complete the form below and send it back to your children's school by (insert date) if you do not want your children's free and reduced price meal eligibility information shared with Medicaid or the State children's health insurance program. If you want further information, you may call (name of a school contact person) at (phone).

☐ I do not want school officials to share information from my free and reduced price school meal application with Medicaid or the State children's health insurance program.

Child's Name	_____	School	_____
Child's Name	_____	School	_____
Child's Name	_____	School	_____

Signature of Parent/Guardian _____ Date _____

Printed name _____
Address _____